



Seattle Indian Health Board

For the Love of Native People

611 12th Avenue South

Seattle, WA 98144

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www.sihb.org

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Esther Lucero

Chief Executive Officer

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Hon. Ruben Gallego

Chairman, Subcommittee for Indigenous Peoples of the United States

Longworth House Office Building 1324

Washington, DC 20510

Dear Chairman Gallego:

The Seattle Indian Health Board thanks you and the Subcommittee for Indigenous Peoples of the United States for holding the hearing, *"Reviewing the Broken Promises Report: Examining the Chronic Federal Funding Shortfalls in Indian Country."* We appreciate the opportunity to provide written comments to the Subcommittee on the needs of Urban Indian Health Programs.

The Seattle Indian Health Board is one of the 41 Urban Indian Health Programs that assist the federal government in fulfilling their trust responsibility to provide healthcare for the American Indian and Alaska Native citizens living in urban areas. Urban Indian Health Programs are a critical component of the Indian Health Service (IHS) IHS Direct, Tribal 628, Urban Indian Health Program (I/T/U system of care) and offer culturally attuned health services in 117 counties across 24 states where 1.5 million American Indians and Alaska Natives live. Nationwide, more than 70% of the American Indian and Alaska Native population live in urban areas, yet Urban Indian Health Programs receive less than one percent of the IHS budget.

Seattle Indian Health Board ensures the health and well-being of urban American Indian and Alaska Native communities by providing culturally attuned healthcare and human services, conducting data research through our research division the Urban Indian Health Institute, and collaborating with tribal, community, and federal partners on policy and advocacy issues that impact urban Indian communities.

As an Indigenous organization, we are guided by our traditional beliefs and practices, giving us a unique organizational approach based in indigenous knowledge that we define as Indigenous Knowledge Informed Systems of Care. This allows us to approach all aspects of our organization, through a holistic system of care. By creating a system that is centered on the patient and driven by Traditional Indian Medicine, we build on our

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resilience to build healthier communities. Our Indigenous Knowledge Informed Systems of Care approach guides our policy advocacy, data research, workforce development, and health and human services to create an environment anchored in tradition, that empowers our community to walk in a culture of wellness.

In response to the findings of the United States Commission on Civil Rights (USCCR) 2019 Report *Broken Promises: Continuing Federal Funding Shortfall for Native Americans* and the 2003 USCCR report: *A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country*, we submit the following requests to the subcommittee. These requests will begin to address the chronic underfunding of trust and treaty obligations to American Indian and Alaska Native people living in urban areas.

1) Authorize Advance Appropriations for Indian Health Service (IHS)

It is well documented that the IHS does not receive funding parity with other discretionary or mandatory federal health care programs such as the Veterans Health Administration, Medicaid, and Medicare. As a result, government shutdowns are threatening the health and wellness of the American Indian and Alaska Native community across the I/T/U system of care. We request Congress authorize advance appropriations to honor the trust and treaty obligations to American Indian and Alaska Native citizens and address the negative impacts of government shutdowns on healthcare delivery.

2) Appropriate \$58.9 billion to fully fund the Indian Health Service

The IHS is currently funded at \$5.1 billion and has been chronically underfunded since its inception. As a result, just a fraction of eligible American Indian and Alaska Native people access healthcare services through the I/T/U system of care. SIHB estimates that it will take an investment of \$58.9 billion to fully fund direct healthcare services through the I/T/U system of care. Our estimate accounts for all American Indian and Alaska Native people that may be eligible for IHS services nationwide and creates spending parity between the IHS and the general population. Additional funding would be required to address the chronic underfunding of healthcare infrastructure across the I/T/U system of care.

3) Appropriate \$60 million to the 12 Indian Health Service Tribal Epidemiology Centers

Tribal Epidemiology Centers provide epidemiology and public health functions critical to the delivery of healthcare services for the I/T/U system of care and are authorized public health authorities for urban Indian communities and tribal communities within their service

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areas. Tribal Epidemiology Centers remain woefully underfunded despite marked success and un-replicated services. On average, Tribal Epidemiology Centers receive \$340,000 a year from IHS. Many Tribal Epidemiology Centers must seek out additional funding public and private funding sources to sustain core services. Increased funding would allow Tribal Epidemiology Centers to conduct the culturally attuned research, data, and evaluation services needed to perform their core functions as defined in 25 USC § 1621m.

Tribal Epidemiology Centers are also uniquely positioned to address data challenges surrounding the Missing and Murdered Indigenous Women and Girls crisis by developing community-led demographic data collection and reporting standards for law enforcement agencies including best practices for collecting race, ethnicity, and tribal affiliation; and developing guidelines around Indigenous Data Sovereignty practices that allow tribal nations to govern the collection, ownership, and application of its own data, including any data collected on its tribal citizens. Full funding of Tribal Epidemiology Centers will increase organizational capacity to offer these services to tribes, Urban Indian Health Programs, and partner agencies.

4) Create an Urban Confer policy across the United States Health and Human Services Department (HHS)

The federal government has an obligation to consult with Tribal Nations on issues that impact tribal communities. In the Indian healthcare system, Urban Indian Health Programs (UIHP) have a have Urban Confer mechanism that provides an opportunity for an exchange of information and opinions that lead to mutual understanding and emphasize trust, respect, and shared responsibility between UIHPs and government agencies. SIHB suggests that HHS implement an Urban Confer policy across all agencies and departments within HHS jurisdiction. Urban Confer policies do not substitute for nor invoke the rights of a Tribe as a sovereign nation. UIHP inclusion is to advocate for the urban Indian community as an Indian Health Care Provider and part of the I/T/U system of care.

5) Amend Social Security Act 1905(b) to include Urban Indian Health Programs

Urban Indian Health Programs receive less than 1% of the IHS budget. Yet, over 70% of American Indian and Alaska Native people live in urban areas. The Seattle Indian Health Board, and many UIHPs serve a growing number of urban American Indian and Alaska Native people. UIHPs are the only part of the I/T/U system of care that are not 100% FMAP payment eligible despite being Indian Health Providers stipulated in Title V in the Indian Health Care Improvement Act (IHCIA), now Subchapter IV of the IHCIA as amended by



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the Affordable Care Act (ACA) in 2010. SIHB requests that section 1905(b) of the Social Security Act be amended to include UIHPs to move towards fulfillment of the federal trust responsibility to provide healthcare to American Indian and Alaska Native people.

6) Conduct an Urban Indian Health Program Infrastructure Needs Assessment

We request the IHS Office of Urban Indian Health Programs conduct a full assessment of the infrastructure needs of all 41 UIHPs to document and estimate the capacity, condition, and needs of facilities in order to improve data driven decision making and to outline a clear funding strategy for modernizing all I/T/U healthcare infrastructure.

7) Permanently Reauthorize the Special Diabetes Program for Indians (SDPI)

Type 2 diabetes is more prevalent in American Indian and Alaska Native people than in any other race and is two times higher than that of non-Hispanic Whites. Since 1996, the SDPI has proven to be an inexpensive and highly cost-saving measure of diabetes care and prevention. The SDPI program has saved millions of Medicaid dollars through prevention and management of diabetes and associated health problems such as hypertension, cardiovascular disease, retinopathy, neuropathy, and end-stage renal disease. SIHB requests, the SDPI program t be permanently reauthorized and fully funded to ensure that all American Indian and Alaska Native people have access to culturally-attuned chronic disease prevention and management services.

8) Extending Indian Preference for Housing Assistance

The federal government has a federal trust responsibility to provide affordable housing in partnership with Indian tribes to improve the housing conditions and socioeconomic status of American Indian and Alaska Native citizens. Yet, American Indian and Alaska Natives are three to eight times more likely to experience homelessness than other racial and ethnic groups. To address the housing needs of urban American Indian and Alaska Native people, SIHB requests that Tribal Housing Entities be allowed to extend Indian Preference Policy to affordable housing developments administrated by Urban Indian Organizations through Memorandums of Understanding (MOU), without having to allocate Indian Housing Block Grant program funding to a housing project.

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www.sihb.org**9) Direct Services and Programming Carve Outs for Gender-Based Violence Programs**

American Indian and Alaska Native people disproportionately experience violence. For example, more than 4 in 5 American Indian and Alaska Native women (84.3 percent) have experienced violence in their lifetime. These numbers likely underestimate the true extent of violence due to systematic racism, underreporting, misclassification, and ongoing distrust of law enforcement. Despite this ongoing crisis of violence, very little is known about the victimization of American Indian and Alaska Native women living in urban settings, outside of the recent research by the Urban Indian Health Institute, an IHS funded Tribal Epidemiology Center.

Through the I/T/U system of care, tribal and urban Indian organizations play a critical role in preventing and ending violence against American Indian and Alaska Native people in partnership with government and community partners. SIHB requests that all federally funded gender-based violence programs include a five percent grant carve out of state and local funds to Urban Indian Organizations that use indigenous approaches to ending gender-based violence through culturally attuned approaches to survivor and family support services, sexual assault prevention, and treatment services.

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